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ABSTRACT

The author describes "Comprehensive Care for Families," an outpatient community mental health center in Chicago which helps to conduct a consultation project serving public school classes for the emotionally disturbed. Based upon students' own expression of goals, a group treatment program was initiated to increase self concept, expressiveness, concern for themselves and others, ability to recognize the affects of their behavior, and awareness of their own strengths. Group sessions include role playing, modeling, paper-pencil tasks, and art. Informal evaluations indicate an overall improvement in student behavior and increased classroom time for academic rather than disciplinary tasks. (CL)

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# In-School Consultation and Treatment Issues

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## In-School Consultation and Treatment Issues

Educators, mental health professionals and other child care providers have addressed the psycho-educational needs of the emotionally disturbed child by offering a continumm of services within the least restrictive placement. In accordance with Public Law 94-142 mandates, these children have been placed in a number of settings, ranging from the regular classroom in regular, special education classrooms, day treatment facilities, hospitals, and residential centers.

The goals of special education, (regardless of the setting) have been geared towards reducing the learning barriers which inhibit academic growth in a emotionally handicapped child. Many times, priorities of special education administrators have focused on remediating the perceptual, cognitive, motor, and language skills of the child, with less emphasis placed on the teaching of appropriate social behaviors. When in fact it was the manifestation of maladaptive behaviors which determined the child's placement in a program for the emotionally disturbed.

Maybe it was assummed that reduced teacher-student ratios would catalyze behavior change in itself when in many instances teachers assigned to teach these children are given the minimum of training and support necessary to effect significant behavior change.

If we believe in the concept that making it in school is a necessary pre-condition to a broad range of critical life conditions and the ultimate goal is to mainstream handicapped children into the regular classroom, then we must begin addressing the problems of motivation, stress, tolerance, and self-esteem as critical barriers interfering with the child's learning process and social adaptation, (Cowen, 1973).

Many children placed in special education programs, particularly those serving the behavior disordered have experienced an overwhelming number of frustrations in school and the home as well as the community. Repetitives failures have been internalized. What emerges is a child feeling that he (she) is incapable of successful experience. The behavior patterns we observe in the classroom, e.g., aggressiveness, fighting, cursing, withdrawal, and negativism are developed defensively, as maladaptive coping patterns to mask an underlying fear of failure and feelings of hopelessness.

Certainly, we must be in agreement that family and school are among the most important systems which shape a child's development. Theoretically speaking, the local school system assumes the responsibility of education and the social development of child is placed in the hands of the family. In the case of the emotionally disturbed child, should one disunite family and school rather than approach both as complementary community resources?

It is impractical to assume that school districts, responsible for hundreds of thousands of students; plagued with fiscal restraints and conservative budgets can successfully provide within a six-hour day, the "gamut" of services necessary to meet both the educational and emotional needs for the behavior disordered child.

In order to meet the challenges and the multiplicity of problems these children bring to the special education classroom, it has become a necessity for local school districts to tap into exisiting community resources, (beyond the referral and follow-up process), to establish a viable network system to service the total needs of the emotionally handicapped child.

Comprehensive Care for Families, an out-patient community mental health center is a non-profit state-supported agency. For the past three years, the agency in cooperation with the Chicago Public Schools and the Illinois Department of Mental Health and Developmental Disabilities have conducted an in-school consultation project serving public school classrooms for the emotionally disturbed child. These classrooms were established by the Chicago Public Schools in 1977. A child is eligible for placement in an ED classroom if he (she) exhibits a variety of affective or maladaptive behaviors that need change regardless of the level of academic achievement. Prior to a child's placement in this classroom, he (she) must be screened, evaluated (including a psychological, psychiatric, and medical assessment), and staffed

by a multidisciplinary team. The child is reviewed semi-annually. The termination of a child in an Ed program is based upon two factors. The child's individualized educational plan demonstrates a need for a different special education program, or the staffing report shows the goals have been met, and there is no longer a need for special education.

This is the third year of the "In-School" Consultation project. The philosophy of our project is "Education as therapy, therapy as education." The goals are to re-educate not only the children but teachers and parents as well by giving them the necessary skills and resources which tap their resources and assist them in solving their problems and meeting their goals.

When the consultant team from Comprehensive Care for Families began working in the schools, it also found through interviews and observing classrooms, both teachers and master teachers expressed a lack of adequate planning periods to prepare for their classes. Priorities for the classroom focused upon continous progress and crisis intervention for daily behavioral disruptions. Because of the dynamics of the room itself, little time was afforded for "therapeutic" education. Valuable class time was usually spent on academic remediation and discipline, while simultaneously glossing over the emotional needs of the child.

Based upon these initial classroom observations, interviews with teachers, school administraters, and support staff, it was the task of the consultant team to develop a three-fold consultation project in Garrett A Morgan elementary school.

The first component was to serve as a supportive resource for teachers and teacher aides assigned to the ED classrooms. In a school system faced with tremendous personnel cut backs, it was our initial goal to insure staff we were not evaluating their performance, or encroaching on their professional turf. We conveyed the notion that our presence was to enhance their effectiveness as teachers and descrease their time spent in disciplining problematic behaviors.

Teachers were given resource guides designed to broaden their awareness of mental health facts and principles, and the psychological factors involved in many behaviors and situations. The consultant team made themselves available on a weekly basis to confer with teachers on the behavior patterns of a particular child, problematic situations, along with suggestions for teaching prescriptions.

After completing the teacher orientation, parents were interviewed (in some instances, home visits were made), and parental permission was obtained for the child's participation in the program. In attempts to engage parents in their child's therapy program, the staff arranged parties, outings, and other social activities at the offices of Comprehensive Care for Families.

In preparation for the group therapy program, the school social worker was asked to assess the social and behavioral needs of each child in accordance with the child's individualized educational plan. With the input of support staff, parents, and teachers, behavioral goals were established for each classroom in the form of group objectives.

The potential group participants were seen individually for no more than five sessions in preparation for the group. Upon the close of the problem-oriented individual sessions, each child was asked to identify specific behaviors which needed continued improvement. Interestingly, most children identified similiar self-goals. They were, "Not getting mad," "Making friends," "Sitting still," "Controlling myself," "Paying attention," and "Not talking back." Those children who had been placed in ED classrooms for two or more semesters, emphasized their eagerness to return to the regular classrooms.

Based upon the expressed behavioral goals of the student coupled with input from school personnel and parents, a group treatment program was implemented with the following objectives:

1.) Increase group members self concept through the use of success oriented peer experiences.

2.) Increase the group members expression of thoughts, feelings, and ideas in socially acceptable ways.

3.) Increase group members ability to demonstrate concern for themselves and other group members.

4.) Increase group members ability to recognize their behavior and how their actions affect others around them.

5.) Increase group members awareness of their own personal strengths in spite perceived limitations and abilities.

Each ED classroom at Morgan has group sessions on a weekly basis. The primary group sessions are limited to forty minutes, and the intermediate group consists of 60 minutes sessions. To stimulate continued parental involvement, group information slips are distributed to parents for the purpose of informing them of

appropriate and inappropriate behaviors and their child's progress in the group.

Needless to say, the theoretical influences of the group are electic. We have adapted a group model based upon Glasser's (1965) Reality Therapy, Rose's (1973) behavioral groups, and Goldberg and Hymowitz's (1971) affective education. We have drawn from nearly every orientation in order to approach the psycho-social needs and behavioral goals of these children. Each group session addressed specific issues, ranging in scope from friendship; the emotions of fear, joy, anger, and frustration; to responsibility and self control; drugs, sex, parents, siblings, and coping with disappointment.

Role playing, modeling, paper-pencil tasks, and art are used to sustain the child's active involvement in the group. For each group session there is a new acrivity and a different topic of discussion. Peer pressure is used effectively to quell potential disruptions during the sessions. Because we are in the middle of school year and formal compilation of data has not been completed, the outcome of the in-school consultation project is yet to be assessed. Informal comments from school personnel suggest there has been an overall improvement in the behavior of the students. Teachers have reported they are able to devote a greater percentage of the school day towards the remediation of academic deficits, rather than serving as disciplinarians of "way ward" youngsters.

Establishing such a program, utilizing non-Board of Education

personnel in the classroom is a painstaking process. Success of a program such as this made possible only through the cooperation of sensitive administrators, school personnel, and mental health consultants. In order to establish a good relationship between the community agencies and public school, the consultant and Board of Education personnel must convey a caring attitude about the school and community, and be sensitive to both verbal and non-verbal reactions of staff. The consultant must rely on the teacher's judgement in areas of her knowledge. The consultant must be available in case of a crisis. The consultant must be clear in his (her) own role, yet flexible. And lastly, the consultant's line of communication and respect for confidentiality should be firmly established to all concerned.

Believe me, we are not without our share of problems. However we eagerly await the final outcome of the "in-school" consultant project. It is a learning process for all of us.

We will view this project as a sucess when we are able to extend mental health in the classrooms to special education programs throughout the public school system.

Supplementary materials available by writing to Georgina Rhoden, M.S. Comprehensive Care for Families, 1950 W. 87th Street, Chicago, Illinois 60620.

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